DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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HOSPITAL BULLETIN

CONTENTS

HOSPITAL OUTPATIENT LABORATORY SERVICES

Under the Clinical Laboratory Improvement Act (CLIA) of 1988, all laboratory testing sites, as defined in 42 CFR 493.2, must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States.

An outside laboratory performing outpatient laboratory services must bill Medicaid for the service when the laboratory is an enrolled Missouri Medicaid provider. A hospital may bill Medicaid for outpatient laboratory services performed by a non-Medicaid enrolled outside laboratory. The billing hospital must keep in their files the appropriate CLIA certification for the outside laboratory performing the services.

HOSPITAL OUTPATIENT CARDIAC REHABILITATION

In order to comply with national standards for transactions and code sets as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, which was enacted on August 21, 1996 and 45 Code of Federal Regulations 162 Subpart J., effective for **DATES OF SERVICE** October 16, 2003 and after, Missouri Medicaid will accept the appropriate revenue code for cardiac rehabilitation services provided in the outpatient department of the hospital. A CPT procedure code is not required when billing for outpatient cardiac rehabilitation services.

Revenue Code	Description
0943	Cardiac Rehabilitation

For more information concerning outpatient cardiac rehabilitation services please reference Section 13.47 of the Hospital Manual at www.dss.state.mo.us/dms.

STERILIZATION, HYSTERECTOMY, CERTIFICATE OF MEDICAL NECESSITY, PRIOR AUTHORIZATION AND INPATIENT SECOND SURGICAL OPINION FORMS

As stated in Hospital Bulletin Volume 26 Number 1 (October 8, 2003) effective for **DATES OF SERVICE** October 16, 2003 and after, hospitals must report inpatient surgeries on all types of inpatient claim forms using ICD-9-CM surgical procedure codes. If the surgical procedure performed during the inpatient stay requires completion of an Acknowledgement of Receipt of Hysterectomy Information form, Certificate of Medical Necessity form, Prior Authorization Request form, (Sterilization) Consent Form or Second Surgical Opinion form, it is the responsibility of the hospital to obtain from the physician a copy of such forms to keep in the recipient's chart. For a complete list of codes for which the above referenced forms are to be used, refer to the Hospital Manual, Section 14 at www.dss.state.mo.us/dms .

HOSPITAL OUTPATIENT EMERGENCY SERVICES EXEMPT FROM COST SHARING CLARIFICATION

Effective October 16, 2003, Condition Code AJ must be used on the outpatient claim in order to properly identify emergency services that are exempt from the cost sharing requirement. Admission Type 1 (emergency) **IS ALSO REQUIRED** when Condition Code AJ is used. This will replace the X01 diagnosis code used prior to October 16, 2003.

ICD-9-CM PROCEDURE CODE 96.49 CLARIFICATION

ICD-9-CM Procedure Code 96.49 (Other genitourinary instillation) is restricted by Missouri Medicaid and requires a Certificate of Medical Necessity for Abortion. Procedural Cross Coder: Essential Links from ICD-9-CM Volume 3 Procedural Codes to CPT Codes (Ingenex 2004 Edition) crosswalks ICD-9 procedure code 96.49 to CPT procedure codes for abortion. Non-abortion related CPT codes must be crosswalked to ICD-9-CM codes that are not restricted.

REVENUE CODE 0270 CLARIFICATION

When billing a hospital outpatient claim, revenue code 0270 must appear only once on the submitted claim, combining surgical AND medical supplies on the same pricing line.

HOSPITAL INPATIENT SURGICAL PROCEDURE CODE CLARIFICATION

ICD-9-CM procedure codes must be used on all types of hospital inpatient claim submissions with **DATES OF SERVICE** on or after October 16, 2003 to report surgical procedures preformed during the inpatient stay. Do not use the decimal point when entering the ICD-9-CM code on any claim type. For dates of service prior to October 16, 2003 providers must use CPT procedure codes to report surgical procedures performed during the inpatient stay.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the listserve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-800-392-0938 and using Option One.

Provider Communications Hotline
800-392-0938 or 573-751-2896